FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

DPRS-2809

OMB 3206-0202

(Revised (10/10)

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2011 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to: **USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161**

You may fax your form to 888-212-8734. Do not take any action to maintain your present coverage.

COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

Section I. Action. Mark the Change Enrollment block to change your FEHB enrollment.

☐ **Change Enrollment.** I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenance Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure.health**.

Section II. Enrollment Codes and Plan Names. Mark the appropriate blocks. If you are changing your enrollment from **self only** to **self** and **family**, please list your eligible dependents and their birth dates in Section III.

Nationwide Fee-for-Service Plans Open to All

471 ☐ APWU-Self Only
472 ☐ APWU-Self and Family
104 ☐ Blue Cross/Blue Shield-Stnd-Self Only
105 ☐ Blue Cross/Blue Shield-Stnd-Self and Family
111 ☐ Blue Cross/Blue Shield-Basic-Self Only
112 ☐ Blue Cross/Blue Shield-Basic-Self and Family
311 ☐ GEHA-High-Self Only
312 ☐ GEHA-High-Self and Family
314 ☐ GEHA-Stnd-Self Only
315 ☐ GEHA-Stnd-Self and Family
454 ☐ Mail Handlers-Stnd-Self Only
455 ☐ Mail Handlers-Stnd-Self and Family
414 ☐ Mail Handlers-Value Option-Self Only
415 ☐ Mail Handlers-Value Option-Self and Family
321 ☐ NALC-Self Only
322 ☐ NALC-Self and Family
441 ☐ SAMBA-High-Self Only
442 ☐ SAMBA-High-Self and Family
444 ☐ SAMBA-Stnd-Self Only
445 ☐ SAMBA-Stnd-Self and Family

Nationwide Fee-for-Service Plans Open Only to Specific Groups

401 ☐ Foreign Service-Self Only
402 ☐ Foreign Service-Self and Family
421 ☐ Compass Rose Health Plan-Self Only
422 ☐ Compass Rose Health Plan-Self and Family
431 ☐ Panama Canal Area-Self Only
432 ☐ Panama Canal Area-Self and Family
381 ☐ Rural Carriers-Self Only
382 ☐ Rural Carriers-Self and Family

Nationwide High Deductible and Consumer-Driven Health Plans

474 ☐ APWU-CDHP-Self Only
475 ☐ APWU-CDHP-Self and Family
341 ☐ GEHA-HDHP Self Only
342 ☐ GEHA-HDHP Self and Family
481 ☐ Mail Handlers-HDHP-Self Only
482 ☐ Mail Handlers-HDHP-Self and Family

HMO Plan or HDHP or CDHP

Enrollment Code	Name of Plan

Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.

Section III. Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Unmarried dependent child under age 22; 09. Adopted child; 17. Step child; 10. Foster child; or recognized child; 99. Unmarried disabled child over age 22 incapable of self-support because of a physical or mental disability that began before age 22. List additional dependents on a separate page.

Name of Family Member (last, first, middle initial)	Social Security number	Date of Birth	Sex ☐ M ☐ F	Relationship Code
Address (if different from enrollee)		Medicare ☐ A ☐ B ☐ D	TRICARE	Other Insurance ☐
		Name of Insurance		Insurance Policy Number

Section IV. Address Correction

☐ I need to correct my address. The changes are indicated in the box below.

Section V. Authorization. You must sign and date this form. Enter the daytime area code and telephone number where you can be contacted to answer questions.

Signature Daytime Telephone Number Date